Bilateral Chronic Infection of the Glands of Montgomery: *

Report of a Case

WINFRED L. SUGG, M.D.

From the Department of Surgery, Washington University School of Medicine, St. Louis, Missouri

THE MAMMARY AREOLA contains glands of three types: sweat, accessory mammary, and sebaceous. The latter, Montgomery's Glands, 12 to 15 in number, project as small tubercles and are known as Morgagni's tubercles.[1] During pregnancy the glands of Montgomery actively secrete sebum and at times become the sites of low-grade and persistent infections. Following is a case report of such an infection and its surgical treatment.

Case Report

V. J. B. is a 32-year-old white woman. She first noted drainage about the right breast at age 25 shortly after the birth of her last child, whom she did not nurse. First the right breast was tender and swollen around the nipple. Then draining sinuses appeared and these did not heal. At age 27, an incision and drainage of the sinuses was carried out, but three weeks later the tenderness and drainage recurred.

At age 29 she was admitted to Barnes Hospital for the first time. Examination showed a sinus opening in the areola of the right breast about 0.5 cm. superior to the nipple. Nothing abnormal could be seen or felt beyond the areola. The left breast was normal. White blood count was 11,950; fasting blood sugar 70 mg.%; blood urea nitrogen 11 mg.%. Cultures of the draining sinus grew a few colonies of white staphylococci, a moderate growth of yellow non-hemolytic staphylococci coagulase positive. Some gram-negative bacilli were seen in the thioglycollate broth but did not grow on subculture either aerobically or anaerobically. She was operated upon and a sinus tract was found to extend from the upper outer quadrant to the upper inner quadrant of the areola. This was opened and a portion of the tract was removed. The tract was confined to the areola. Microscopically the tissue showed acute and chronic inflammation with fibrosis. No granulomatous

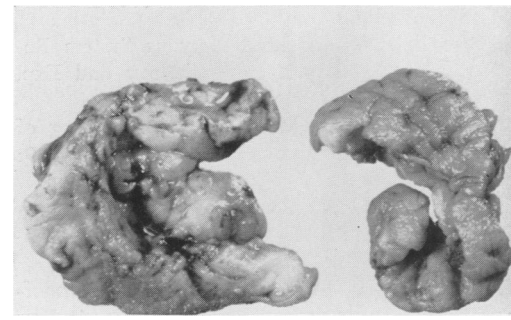

FIG. 1. Excised areolar tissue from both breasts.

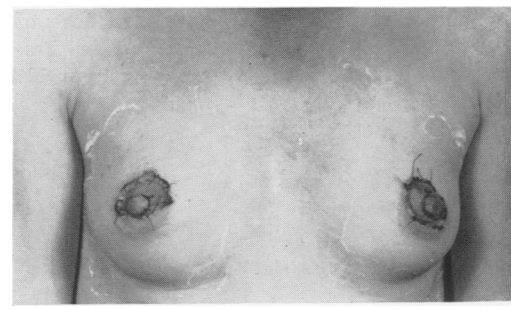

FIG. 2. Doughnut shaped split-thickness skin grafts seven days postoperatively.

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process was found. Five days postoperatively she was discharged with instructions to apply wet soaks to the breast at home. She was seen in the outpatient clinic and at the time of her last visit, three weeks later, the wound had almost completely healed.

She was not seen again until two years later. Five months before this admission she noted a recurrence of drainage from the right breast and three months before drainage appeared from the left breast. She had not been pregnant during the two years. There was scarring of the areola of the right breast and two draining sinuses superior to the nipple. The nipple appeared normal as did the rest of the right breast. In the areola of the left breast was a sinus inferior to the nipple. The nipple and the rest of the left breast were normal. White blood count was 5,560.

She was treated by excising the skin of the areolas only and replacing it with a doughnut cut split skin graft taken from the back (Fig. 1, 2). No extension of the disease was found beneath the areolar epithelium. The areolar tissue removed showed acute and chronic inflammation (Fig. 3, 4). No extension of the inflammation beyond the areola was found. Re-

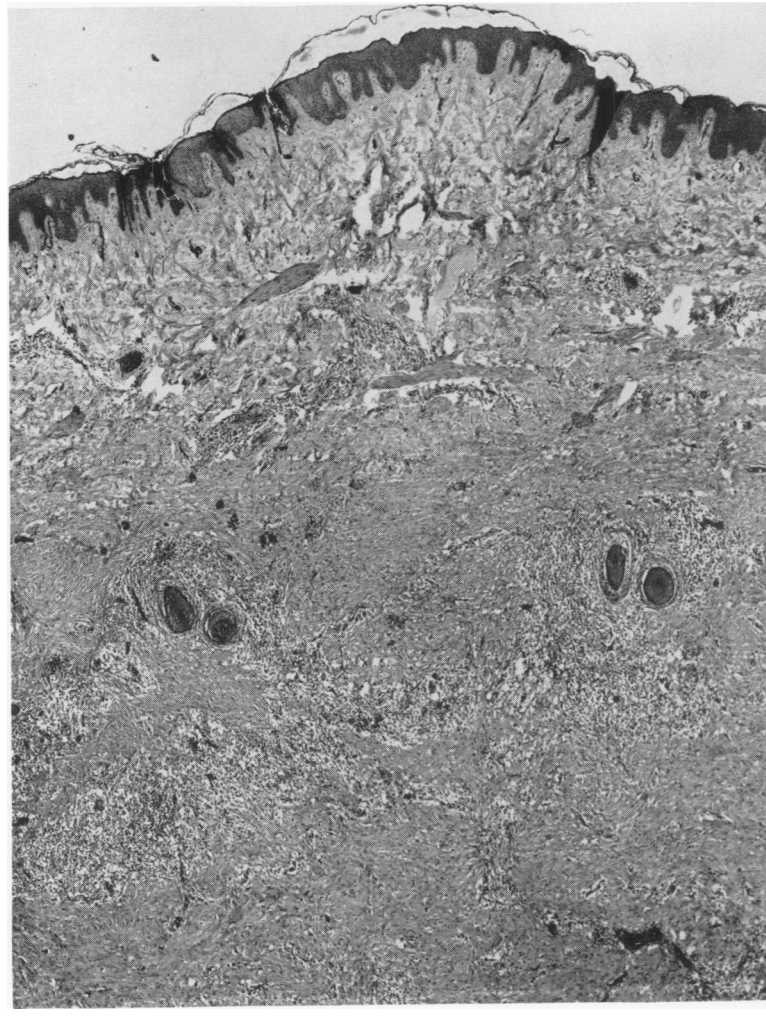

FIG. 3. Area of chronic inflammation with numerous giant cells. These changes are in the region of the glands of Montgomery and are changes compatible with rupture and infection of these glands. Low power magnification (38 ×).

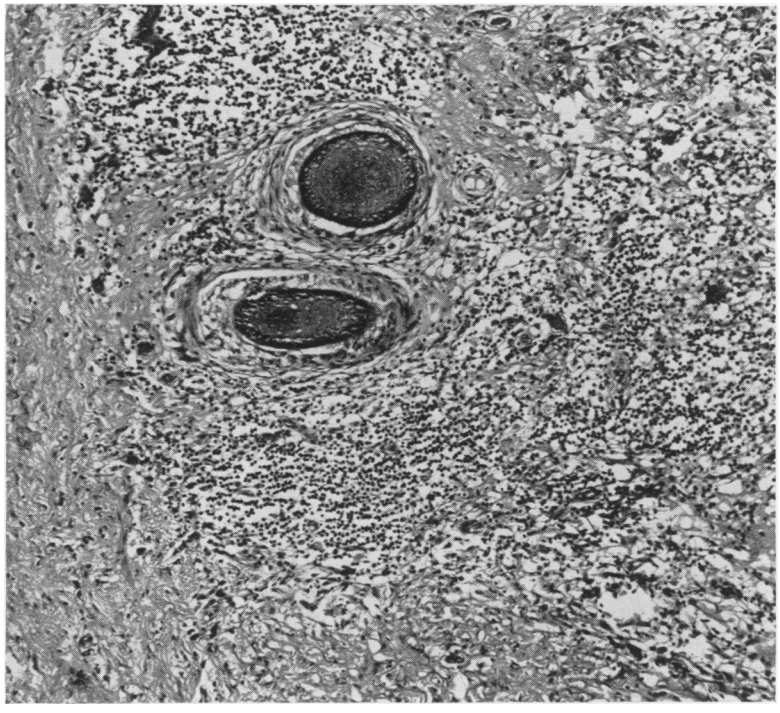

FIG. 4. High power magnification of Figure 3. Two hair follicles are seen on cross section (130 ×).

covery was prompt, with complete take of both skin grafts. She has had no further symptoms.

Summary

A case of infection of the glands of Montgomery is reported. It is recommended that complete excision of the areolar tissue with application of split-thickness skin grafts be carried out whenever this disease is encountered.

Acknowledgment

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Bibliography

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